State of California—Health and Human Services Agency

California Department of Health Services
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
1615 Capitol Avenue, MS 3301
P.O. Box 997416
Sacramento, CA 95899-7416
(916) 327-2445

Date sent: _____

HOME HEALTH AIDE (HHA) CERTIFICATION LIST

HHA training programs must use this form to submit student data to the Aide and Technician Certification Section (ATCS) for certification UPON COMPLETION of the HHA training program. DO NOT SEND ANY OTHER FORMS WITH THIS FORM.

Name of school or agency presenting program	❒ 40-hour program ❒ 120-hour program	Date program began	Date program completed

Mailing address (number and street name or P.O. Box)	City	State	ZIP code	HHA School code

I certify that the students listed below have successfully completed an approved home health aide training program, and qualify for HHA certification.

Signature of RN responsible for HHA training program ➤	Telephone number ( )

1. Last name | First name | MI | Date of birth

Mailing address (number and street name or P.O. Box) | City | State | ZIP code

Social security number ____ ____ ____ – ____ ____ – ____ ____ ____ ____ | Telephone number ( )

2. Last name | First name | MI | Date of birth

Mailing address (number and street name or P.O. Box) | City | State | ZIP code

Social security number ____ ____ ____ – ____ ____ – ____ ____ ____ ____ | Telephone number ( )

3. Last name | First name | MI | Date of birth

Mailing address (number and street name or P.O. Box) | City | State | ZIP code

Social security number ____ ____ ____ – ____ ____ – ____ ____ ____ ____ | Telephone number ( )

4. Last name | First name | MI | Date of birth

Mailing address (number and street name or P.O. Box) | City | State | ZIP code

Social security number ____ ____ ____ – ____ ____ – ____ ____ ____ ____ | Telephone number ( )

5. Last name | First name | MI | Date of birth

Mailing address (number and street name or P.O. Box) | City | State | ZIP code

Social security number ____ ____ ____ – ____ ____ – ____ ____ ____ ____ | Telephone number ( )

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6. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			
7. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			
8. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			
9. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			
10. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			
11. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			
12. Last name	First name	MI	Date of birth		
Mailing address (number and street name or P.O. Box)		City	State	ZIP code	
Social security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Telephone number ( )			

(ATTACH ADDITIONAL SHEETS IF NECESSARY.)

Information Collection and Access: Privacy Statement

This information is requested by the Department of Health Services, Licensing and Certification, Aide and Technician Certification Section (ATCS) under Health and Safety Code, Sections 1736.1 through 1736.6 in order to process requests for home health aide certification. Providing this information is mandatory for purposes of identification only in order to fulfill the State's responsibilities under federal regulations, 42 CFR 484.36. The Department will not initially disclose this information to any other inquirer. For more information, contact ATCS at the address on the front of this form.